Westcare (Somerset) Ltd

Avalon Court Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Avalon Court Residential Home is registered to provide care and accommodation for up to 16 older people. At this inspection there were 16 people living at the home. One person had recently moved into the home. The home has a number of people who wish to live a more independent lifestyle within the safety and security of the care home. The provider offers respite (short stay) care.

The home is an older building; it has two floors with communal spaces such as lounges and a dining room on the ground floor. There is a small paved area to the side of the home with a covered area for people who enjoy fresh air. People were able to freely move between the building and the patio area. At this inspection everyone had their own individual bedroom. People were able to personalise their bedrooms.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good.

Why the service is rated Good

The home continued to ensure people were safe. There were enough suitable staff to meet people's needs and to spend some time socialising with them. Further recruitment was ongoing for care staff and an activities coordinator. Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. The provider, registered manager and staff continued to encourage people to remain independent. People received their medicines safely and, where possible, were supported to administer their own medicines. People were protected from abuse because staff understood how to keep them safe and informed us concerns would be followed up if they were raised.

People continued to receive mainly effective care. However, we made a recommendation in relation to ensuring legislation is followed relating to applications for the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to assess the requirement to lawfully deprive a person of their liberty when they lack the mental capacity to consent to treatment or care and need protecting from avoidable harm. Improvements were being made throughout the inspection to ensure people who lacked capacity were having decisions made in line with current legislation. Staff received training to ensure they had the skills and knowledge required to effectively support people. People told us and we saw their healthcare needs were met. People received support to eat and drink sufficient amounts.

The home continued to provide a caring service to people. People and their relatives told us, and we observed that staff were kind and patient. People's privacy and dignity was respected by staff and their cultural or religious needs were valued. People were involved in decisions about the care and support they received. People's choices were always respected and staff encouraged choice for those who struggled to communicate with them. When people were unable to visit people staff supported them to remain in touch using other methods.

The service remained responsive to people's individual needs. Care and support was personalised to each

person which ensured they were able to make choices about their day to day lives. There were some activities to provide a range of opportunities and care staff helped whilst the activities coordinator was being replaced. These considered people's hobbies and interests and reflected people's preferences. People knew how to complain and there were always opportunities for them to discuss concerns with the registered manager and provider.

The service continued to be well led. People, relatives and staff spoke highly about the registered manager. The registered manager and provider continually monitored the quality of the service and made improvements in accordance with people's changing needs. When concerns were raised during the inspection the management were proactive in responding to them. The registered manager was continually trying to improve their own knowledge so they could effectively support staff.

We have made a recommendation about DoLS.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service now Requires Improvement.	**Requires Improvement**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Avalon Court Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 21 July 2017 and was an unannounced comprehensive inspection. It was carried out by one inspector.

Before the inspection, we looked at information we held about the provider and home. This included their Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account during the inspection.

We spoke in depth with five people that lived at the home and had more informal conversations with others. We spoke with the provider, registered manager, deputy manager and three staff members, including a chef and care staff. We spoke with two visitors who regularly visited the home.

We looked at five people's care records and observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at three staff files, previous inspection reports, rotas, audits, staff training and supervision records, health and safety paperwork, accident and incident records, complement records, minutes from staff meetings and a selection of the provider's policies.

Following the inspection we asked for some information from the registered manager and provider

including some actions taken for things we identified during the inspection. The registered manager and provider returned all information within the required time frame.

Good

Is the service safe?

Our findings

The home continued to provide a safe service to people. People told us they felt safe and their visitors confirmed this. One person said, "[Staff] are always interested in helping you with what you want". Another person explained they were regularly checked at night because they had high levels of anxiety which made them feel safe. One relative said, "Oh yes" when we asked if their family member was safe at the home. Another relative confirmed regular checks were happening to keep their family member safe. They told us, "They [meaning the staff] pop their head in so she sees people".

People were supported by enough staff to meet their care needs and keep them safe. There were occasions when people were not engaged in activities because an activities coordinator had just resigned. One member of staff explained recently staff levels had been difficult due to staff taking holidays and an activity coordinator leaving. They said, "We pull together when we need to" so it did not have an impact on people. The provider told us and we saw there was a low staff turnover and a core team of long term staff. The registered manager explained they had just recruited a new member of night staff. There were further plans to recruit a new activities coordinator and at least one more part time member of care staff.

The PIR told us and we saw people were kept safe because they were supported by staff who understood and recognised signs of abuse. One member of staff said, "The resident is first they must be safe" when explaining how to protect someone. All staff told us they would report any concerns to the management. For example, one member of staff said, "I would report it to [registered manager's name] straight away". They were confident appropriate actions would be taken.

People were supported by staff who had been through a suitable recruitment procedure. This included checks on staff suitability to work with vulnerable people and references from previous employers. One member of staff from overseas told us there had been a check both in this country and their country of origin. However, we found one member of staff did not have a full employment history in line with current legislation. The registered manager immediately followed this up by speaking with the member of staff.

The PIR told us and we saw risk assessments were carried out to ensure people's health and well-being and to promote independence. For example, one person had been assessed at high risk of falls so hourly checks from staff had been put in place. Other people had risk assessments in place to administer some of their medicines themselves. Those at high risk of pressure related injuries had risk assessments in place. There were proactive measures in place such as special cushions on their chairs to reduce the risk of injury.

People were kept safe because accidents and incidents were monitored every month by the registered manager. When patterns had been identified, actions were taken. For example, during June 2017 one person was identified as falling twice in the month. No pattern to these falls was identified so staff were informed and asked to regularly check the person.

People's medicines were safely managed and administered by staff who had received appropriate training. There were systems to audit medication practices and clear records were kept to show when medicines had

been administered or refused. However, one person was on a medicine where certain food could have a negative reaction with it. The registered manager and staff had not been aware of this. The person had not received any of this food. Following the inspection a staff meeting was held by the registered manager to share this information and the person's care plan was updated about the risk. By doing this the person was being kept safe from possible harm.

Requires Improvement

Is the service effective?

Our findings

The service required improvement to continue to provide fully effective care. We saw people were asked for their consent before staff supported them. Some people lacked capacity to make all decisions about their life due to their diagnosis of dementia or medicines they were taking.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff spoken with were aware of the need to assess people's capacity and make day to day decisions for them when they were unable. For example, one member of staff spoke about checking whether someone understood about food choices by showing them the options. They told us if the person remained confused they would consider what food the person usually had.

However, there were occasions when staff had become a little confused about current legislation for people who lacked capacity. For example, one person who had capacity had a completed capacity assessment which was not required. Two people requiring special mats to alert staff at night to prevent falls did not have the correct process followed. One member of staff was unsure whether both the people had capacity to consent to the mats use. For one of the people, there was already a capacity assessment and best interest completed for another decision. One person thought the mat was to protect the floor and the other person was confused about its purpose. Neither had consented or had the necessary steps followed in line with the MCA principles. Although for safety, this is a potentially restrictive practice. During the inspection the provider purchased national guidance for staff to refer to. Following the inspection the registered manager and provider completed some necessary paperwork for people using the special mats. The registered manager told us they were sourcing training for themselves and the deputy manager to improve their knowledge around the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person had an authorised DoLS in place with four conditions which the staff were following. However, one person's health had recently declined leading them to lack the ability to make certain decisions. They were now being monitored 24 hours a day and unable to leave the home unaccompanied to keep them safe; there was no DoLS in place or application for one. This meant there was a risk their human rights was being breached. During the inspection the registered manager completed an urgent DoLS and was submitting a DoLS application to protect this person's human rights.

We recommend that the service consider current national guidance and training for staff on DoLS and take action to update their practice.

People told us and we saw they enjoyed the food which was served. One person said, "Oh perfect" when asked them about the food. They explained every morning they were offered choices for their meals. Another person told us the food is "Marvellous" and explained how the staff adapted food to meet their dietary requirements.

People were able to choose where they ate. For example, we saw some people eating in the dining area, some in the lounge and some in their bedrooms. One relative explained they would bring in special treats for their family member so they could have their favourite. They told us this had never been a problem and the chef always prepared it.

People saw healthcare professionals according to their individual needs. One person told us, "The doctor came to see my legs" because they were sore. During the inspection two people were brought their new glasses by the opticians. One person's care plan demonstrated they had received recent visits from a range of healthcare professionals including an occupational therapist, district nurses and a physiotherapist.

The PIR told us and we saw people were supported by staff who had received training to meet their needs. One member of staff told us they had recently completed an advanced medicine administration course. Some care staff had additional training in health and social care qualifications or were working towards them. All new staff had received an induction which helped orientate them with the home and people. For those new to working in care there was a more in depth induction in line with current national standards.

Good

Is the service caring?

Our findings

The home continued to provide a caring service to people. People told us and we saw staff were kind and caring. One person said, "It's perfect. They [meaning the staff] are fabulous". Other people told us, "Staff are very good. They are always interested in helping you with what you want. I wouldn't change them", "Everybody is so nice", "The staff are marvellous" and "The staff are good. Couldn't fault them for anything at all". One relative told us they had, "Never had such a wonderful reception" when visiting care homes. They continued, "[The staff] make them extremely welcome".

Complements reflected what people and visitors told us about the home. Some examples were, "Thank you so much for looking after mum. I always knew she was well looked after and she was content staying at the home" and "Many grateful thanks for giving [name of person] such excellent care".

People were supported by staff in a caring and unhurried manner. For example, one person was in their bedroom eating their pudding. A member of staff came to collect their tray and take it to the kitchen. The person had not finished their food so the member of staff said, "Don't worry I will come back later".

People were encouraged to make choices and these were respected by staff. For example, people were able to choose where they spent their time during the day. We saw some chose to be in the lounge whilst others spent time in their bedroom. Staff supported people less able to verbally communicate choices using a variety of methods. For example, one member of staff said, "I help [people] choose their own clothes". They explained they show the person options of clothes suitable for the weather that day; then the person picked which clothes they wanted.

People had visitors and could choose where they spoke with them. We saw some people stayed in the main lounge whilst others had visitors to their bedrooms. When people were unable to have visitors staff supported them to stay in touch. For example, one person asked to use the telephone to speak with a relative. A member of staff stopped what they were doing to get the telephone for them. They were supported to dial the number and then left to speak on the telephone. One relative confirmed this happened with their family member when they were unable to visit.

People had their cultural and religious needs respected. Every month there was a church service in the home people could attend. Some people chose to attend the church service. If people did not want to attend this was respected. One member of staff told us they had previously worked with people from different religions. They explained they researched the religion and made themselves "Personally aware".

People were supported by staff who knew how to protect their privacy and dignity. Staff always knocked on people's doors prior to entering. All staff knew to keep curtains and doors closed when supporting people with intimate care. One member of staff said, "I would make sure people are not wandering into the bedroom" whilst supporting a person with intimate care.

Good

Is the service responsive?

Our findings

The home continued to be responsive. People had care plans which provided information for staff about their care and health needs. For example one person's care plan listed their favourite things throughout the day as, "Listening to the radio and chatting with staff and visitors". Throughout the inspection we saw they had visitors and staff would greet them as they walked passed their bedroom. Another person explained staff knew what their needs and preferences were. The registered manager told us they spoke with people regularly about their care needs. This provided the basis of the individual care plans.

The PIR told us and we saw people's care plans were personalised and included a history of their life. Information of this nature could guide and aid staff when communicating with people living with dementia or a cognitive impairment; it may trigger memories and encourage the person to communicate. For example, one person's care plan included a memory about a first date outside a chip shop in 1947 and they enjoyed travelling to Italy.

People had reviews of their care plans to discuss if any changes were needed. One relative told us, "[Name of the registered manager] invites me to reviews". We saw another person had a record of a recent review. During this the registered manager had discussed the support the person required for intimate care. The person made it clear they wanted to remain as independent as possible. We saw and the person told us this had been respected by the registered manager and staff.

Detailed assessments were completed prior to people moving in so their care and health needs could be identified. For example, one person told us about previous experiences and how they had improved since moving to the home. Their care assessment had identified this and informed staff about support needs, likes and dislikes. Important questions were also asked about whether the person wanted to administer their own medicine. If they did a risk assessment was written and arrangements put in place to make this possible.

People participated in a range of activities to meet their interest. For example, one person told us about their enjoyment of bingo. Another person said, "I always have plenty of puzzle books" and told us about their jigsaws. We saw others were knitting, painting pictures in their bedroom or picking flowers in the garden. The staff and registered manager arranged for visitors into the home to provide activities and entertainment. For example, one person remembered there had been, "People coming up and singing. Men being Elvis Presley". One member of staff told us there was a "Lady who does pom-pom dancing and a lady who does flower arranging". However, there were occasions when people were not engaged in much activity. The registered manager and provider explained they were currently recruiting a new activities coordinator. They also explained care staff were doing as much as they could in this interim period.

People knew how to complain and told us action was taken by the staff when they raised a concern. One person said, "No complaints from me. Just tell them straight from mouth". Another person told us, "I only have to say a word or two and they understand what I am saying" when talking with us about complaints. We saw there had been no formal complaints since the last inspection. The provider explained they had a

very open relationship with people and their relatives which could have prevented concerns escalating.

Good

Is the service well-led?

Our findings

The home continued to be well led. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager explained and we saw they were hands on in their management approach. They would regularly complete shifts and told us this was to lead by example and helped them understand any concerns staff raised.

People spoke highly about the registered manager. One person said, "[The registered manager] is very good". Another person told us the registered manager was "Wonderful". They continued the registered manager "Likes to know what staff are doing". Staff spoke positively about the registered manager. One member of staff said, "[They] are very fair". Whilst another member of staff told us the registered manager, "Knows their job very well".

The registered manager and provider told us there was a clear culture and vision for the home. They wanted it to be homely and provide an open and friendly environment. People, relatives and staff all knew this. One relative said, "It is like home from home". One member of staff explained it was a small home which was, "Friendly and homely". Two members of staff told us working at the home was like having a second family. The provider explained a positive of being a small home was "Staff can spot when people are not themselves without showing huge symptoms". Therefore, they could be proactive about referring them to other health or social care professionals.

The registered manager ensured people received high quality care. They had quality assurance systems which enabled the quality of the care and the environment to be monitored and improved. We looked at some in house audits which included health and safety, infection control, medicine administration and fire safety. By completing these they were monitoring the care and support being given to people.

The provider regularly visited the home to complete informal and formal visits to monitor the quality of care being delivered. They told us they were "Always there for advice" and asked the registered manager for emails to update them. When improvements were identified action had been taken. For example, a small leak was found in the roof so they had arranged for someone to repair it. One person had been identified by the registered manager that a different type of home was required to meet their health and care needs due to their condition declining. The registered manager and provider had followed this up with referrals to other health and social care professionals.

The provider and registered manager had informed external agencies such as the local authority and CQC in line with current legislation. By doing this they were sharing information so others could monitor the care and safety of people living in the home. However, on one occasion they had not informed CQC about the authorisation of a DoLS. Following the inspection this notification was sent to CQC.

The PIR told us and we saw the registered manager and provider continually wanted to make improvements by involving people and staff. One staff member said, "[The registered manager's name] is very open to ideas. Can always talk to [them]". When suggestions had been made using the annual care questionnaire these had been followed up. For example, one relative raised a concern about dead flowers in vases being left in bedrooms. The registered manager had held a group supervision for staff about this. We saw all flowers in vases were alive including those in bedrooms.